Chapter 11:
National Family Caregiver Support Program

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Chapter 11

National Family Caregiver Support Program

11-1: Description of the National Family Caregiver Support Program

The National Family Caregiver Support Program (NFCSP) establishes an infrastructure of program resources and assistance for family caregivers and grandparents or other relative caregivers. The NFCSP in Tennessee shall be provided in accordance with Title III, Part E, of the Older Americans Act (OAA), as amended in 2006, and TCAD Program and Policy Manual. Grants to States, with State Plans approved under Section 307, shall pay for the Federal share of the cost of carrying out State programs to enable area agencies on aging or entities that such area agencies on aging contract with, to provide a multifaceted system of support services. The NFCSP shall be accessible and provided throughout each of the planning and service areas of Tennessee.

11-1-.01: Caregivers

The focus of NFCSP is the caregiver and provides a service delivery system that respond to the needs of the caregiver. **The caregiver is the client in the NFCSP program.** Caregivers include:

(1) Family Caregivers

- (a) Adult family members (age 18 years or older) or other adult informal caregivers providing care to adults age 60 and over and adults with disabilities.
- (b) Adult family members or other adult informal caregivers providing care to individuals of any age with Alzheimer's disease and related disorders and neurological and organic brain dysfunction.

(2) Grandparents and Relative Caregivers

- (a) Grandparents, step-grandparents, or other relatives (not parents) age 55 and older providing care to adults, age 18 to 59, with disabilities
- (b) Grandparents, step-grandparents, or other relatives (not parents) age 55 or older providing care to children under the age of 18 years that:
  - (i) live with a child that is not more than 18 years of age or is an individual with a disability (19-59 years of age with a disability). Disability refers to conditions attributable to mental or physical impairment or to a combination

of mental and physical impairment that results in substantial functional limitations in one or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-sufficient, cognition functioning, and emotional adjustment [see 42 USC 3002 (8)]

(ii) is the primary caregiver of the child because the biological or adoptive parents are unable or unwilling to serve as the primary caregiver of the child.

(iii) has a legal relationship to the child, such as legal custody or guardianship, or is raising the child informally.

11-1-.02: Service Components

The Tennessee Commission on Aging and Disability (TCAD), working in partnership with the nine (9) Area Agencies on Aging and Disability (AAAD) and local community service providers, shall provide five (5) categories of services for caregivers. The number of activities/ contacts/hours/sessions required for each of the 5 categories is indicated in parentheses. The categories are as follows:

(1) Information Services (1 activity)

This service for caregivers provides the public and individuals with information, resources, and services available to the individuals within their community. Information services are activities, such as but not limited to, disseminating publications and conducting media campaigns, directed to a large audience of current and potential caregivers.

(2) Access Assistance

(a) Information and Assistance (1 contact)

This service assists caregivers in obtaining access to the services and resources that are available within the community. To the maximum extent practicable, this service ensures that the individual receives the services needed by establishing adequate follow-up procedures.

(b) Care Management (1 hour)

This service provides assistance either in the form of access or care coordination in circumstances where the care recipient is experiencing diminished functioning

capacities, personal conditions, or other characteristics which require the provision of services by formal service providers or family caregivers. Activities of case management include such practices as assessing needs, developing care plans, authorizing and coordinating services among providers, and providing follow-up and reassessment, as required.

(c) Outreach (1 contact)

This service provides intervention with individuals initiated by an agency or organization for the purpose of identifying potential caregivers and encouraging their use of existing services and benefits.

(3) Individual Counseling, Organization of Support Groups, and Caregiver Training (1 session)

This service is provided to assist the caregivers in the areas of health, nutrition, and financial literacy in order to make decisions and solve problems related to their care giving roles. The services include:

(a) Individual Counseling

Caregiving can be very stressful, both physically and emotionally. Individual counseling allows the caregiver the opportunity to discuss issues related to caregiving such as, but not limited to, identifying signs of caregiver burnout or stress; coping with the emotions such as frustration, feelings of inadequacy, and depression; and, above all, taking care of one's self. A licensed professional counselor should provide individual counseling; however, if a licensed professional counselor is not available, a staff person qualified by training or experience can deliver the service if he/she is supervised by a counselor licensed by the State of Tennessee. The AAADs must have a Licensed Counselor or a counseling agency to which to make a referral if a caregiver is in need of an individual counseling. Licensure can be verified at http://health.state.tn.us/Licensure/index.htm through the Tennessee Department of Health. Licensure includes: Licensed Professional Counselor, Licensed Clinical Social Worker, Licensed Clinical Psychologist, or PhD.

(b) Support Groups

This service offers sessions that allow caregivers the opportunity to discuss their attitudes, feelings, and problem with input from other members of the group; attempt to achieve greater understanding and adjustment; and explore solutions to their problems.

(c) Caregiver Training

This service offers training/education that is designed to assist caregivers with acquiring knowledge and skills that will help them in providing care.

(4) Respite Care

This service offer temporary, substitute supports or living arrangements for care recipients in order to provide a brief period of relief or rest for caregivers. Respite care may include:

(a) in-home respite such as personal care, homemaker services, and sitter service;

(b) respite in a non-residential program such as adult day care;

(c) institutional respite provided by placing the care recipient in an institutional setting such as a nursing home for a short period of time as a respite service to the caregiver; and

(d) summer camps for children.

Transportation of the care recipient to an adult day care center or similar program, such as transporting children to summer camp, may be part of the respite expense.

(5) Supplemental Services

This service is provided on a limited basis to complement the care provided by caregivers. Examples of supplemental services include, but not limited to, home modification, home-delivered meals, medical equipment and supplies, personal emergency response system (PERS), incontinence supplies, and assistive technology. Supplemental services also includes:

(a) Legal assistance that includes counseling as well as training sessions on legal issues should be reported as a supplemental service.

(b) Transportation to medical appointments would be a supplemental service.

11-1-.03: Priority

In providing services, priority shall be given to:

(1) caregivers who are adults age 60 and over with the following conditions:

(a) greatest social need caused by non-economic factors which include physical and mental disabilities; language barriers; and cultural, social and geographic isolation (including racial or ethnic status) that restricts an individual's ability to perform normal daily tasks or threatens his/her capacity to live independently; and

(b) greatest economic need resulting from an income level at or below the poverty line (100%) as defined by the Office of Management and Budget and adjusted by the Secretary of Health and Human Services with particular attention to low-income adults age 60 and over who are providing care to adults age 60 and over.

(2) adults age 60 and over providing care to individuals with severe disabilities, including children with severe disabilities;

(3) family caregivers who provide care for adults age 60 and over with Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(4) grandparents or relative caregivers who provide care for children with severe disabilities.

11-1-.04: Eligibility

Information, assistance, and counseling can be provided to any caregiver, but Respite and Supplemental Services funded under the NFCSP can be provided only if the **care recipient** meets the definition of frail. Frail means an individual that is determined to be functionally impaired according to the following guidelines;

(1) The care recipient is unable to perform at least two (2) Activities of Daily Living (ADL) without substantial human assistance, including verbal reminding, physical cueing, or supervision; and/or

(2) The care recipient has a cognitive or other mental impairment that requires substantial supervision to prevent the individual from harming him/herself or others. Respite and Supplemental Services that are not supported by Title III-E (and state or local matching funds) are not bound by the eligibility restrictions. Any of the five (5) NFCSP service categories may be provided to grandparents, step-grandparents, and other older relative caregivers caring for a child.

Non-citizens are eligible to receive services through the NFCSP. In accordance with AoA guidelines, non-citizens, regardless of the alien status, should not be banned

from services authorized by the OAA and administered by the AoA based solely on their alien status.

11-1-.05: Funding Limitations

(1) It is recommended that caregiver services under the NFCSP not exceed $5,000 annually per individual, but shall not exceed a maximum of $7,000 annually per individual and must have prior approval of the AAAD Director.

(2) The total maximum annual amount of funding per individual must not exceed $7,000 regardless of the funding source including when individuals receive services from multiple funding sources.

(3) Reimbursement for in-home services such as personal care, home-maker, home delivered meals and respite shall not exceed the OAA rate of reimbursement (See HCBS chapter for reimbursement rates.)

(4) No AAAD may use more than ten percent (10%) of its award to provide Title III-E services to grandparents or relative caregivers of a child who is not more than 18 years of age. Services provided to grandparents or relative caregivers providing care for adult children with disabilities that are between 19 and 59 years of age shall not be counted against the 10% ceiling for grandparents and other caregivers.

(5) No AAAD may use more than twenty percent (20%) of its award to provide supplemental services. Supplemental services are flexible enhancements to caregiver support programs designed for the benefit of caregivers. Each AAAD can elect supplemental services based on local needs as long as they are included in the Area Plan and approved by TCAD.

11-1-.06: Administrative Standards

Funds made available under the NFCSP shall supplement, not supplant, any Federal, State, or local funds expended by a State or unit of general purpose local government (including the AAAD) to provide services described in Title III, Part E, Section 373 of the Older Americans Act.

(1) TCAD shall:

(a) designate a coordinator to implement and oversee program development of the NFCSP statewide.

(b) develop and maintain consistent standards and mechanisms for the NFCSP to be implemented statewide. These standards and mechanisms shall be used to assure the quality of services provided in accordance with the Older Americans Act, Administration of Aging regulations and policies, and TCAD policies and rules.

(c) develop standard individual assessment tools to be used by all AAADs.

(d) collect, maintain, and report information in State Reporting Tool (SRT).

(e) provide training to the family caregiver program staff, as needed.

(f) provide technical assistance, as needed.

(g) assume quality assurance responsibilities for all caregiver programs to ensure compliance with standards, policies, and procedures of TCAD and the Older Americans Act.

(2) At a minimum each AAAD shall:

(a) publicize NFCSP services to ensure that individuals throughout the area know about the availability of the services.

(b) provide caregiver information and referral and screen individuals for caregiver support services.

(c) complete an in-home assessment on individuals whose screening indicates need for respite or supplemental services.

(d) arrange for the provision of individually needed family caregiver services directly and/or through local service providers.

(e) organize new and/or coordinate with existing caregiver support groups and caregiver training events.

(f) have a licensed professional counselor referral source to which caregivers can be referred for individual counseling, if needed.

(g) coordinate NFCSP with other programs and service systems serving individuals with disabilities.

(h) use trained volunteers to expand the provision of the five (5) service components.

(i) attend training planned or approved by TCAD.

(j) ensure appropriate program/financial reporting, billing, and budget reconciliation.

(k) negotiate contracts and provide quality assurance program implementation.

(l) compile, maintain, and report waiting lists of persons requesting caregiver services for which service is not available.

(3) Service providers must:

(a) be licensed in accordance with the regulations of the State. Service provider agencies providing in-home services (homemaker and personal care) must have a PSSA license or be licensed as a home health care agency by the Tennessee Department of Health

(b) ensure services and units of service to be provided to individuals consistent with the Provider Authorization

(c) begin services within five (5) working days of the receipt of the Provider Authorization

(d) keep documentation of all contact with or on the behalf of the caregiver and/or care recipient and ensure that the assigned task identified in the Provider Checklist is carried out

(e) keep documentation of each service provided with each visit, which includes a services rendered checklist that is signed by the individual and the worker

(f) have methods and procedures in place for the collection and reporting of individual specific data, including but not limited to rosters, invoices, and daily logs and provide to the AAAD by the 10th day of the month following the month being reported.

11-1-.07: Consumer's Right to Self-Determination

(a) All adult individuals have a right to choose how they will live, as well as where they will live, as long as they are competent to make that decision and able to understand the consequences of their actions.

(b) All adult individuals are presumed legally competent unless they have been deemed in competent by a court.

(c) It is essential to encourage the individual to live in an environment or situation that is safe. The NFCSP is not expected to assist an individual that chooses to continue to live in a situation that is unsafe or to make plans that are unrealistic and unsafe.

(d) Reports to Adult Protective Services (APS) are mandated by state law when "any person" has reasonable cause to suspect abuse, neglect (including self-neglect), or financial exploitation. This includes neighbors, friends, relatives, doctors, dentists, caregiver, agency personnel, etc.
(Adult Protect Act T.C.A. 71-6-103(b) (1)

11-1-.08: Screening

When an individual contacts the AAAD for information about available services, he/she will be assessed using the initial screening/intake. If the I&A staff determines the individual to be a caregiver, he/she will be asked screening questions specifically related to his/her needs as a caregiver. I&A staff will also ask questions about the care recipient. The caregiver is placed on the caregiver wait list. I&A staff should code the call under caregiver if the I&A staff talks directly with the caregiver about his/her need to receive services as a caregiver. The caregiver will be referred to the Family Caregiver Support Program.

11-1-.09: Assessment and Reassessment

If the screening indicates a caregiver's need for respite or supplemental services, the Caregiver Form 2010a shall be completed. The Social Assistance Management System Independent Living Assessment (SAMS ILA) 2016 shall be completed on the care recipient that should include the following minimum sections:

- Section O.A. – Client Identification
- Section 2 – Functional Assessment

All assessments and reassessments shall be completed in a face-to-face interview in the home with the caregiver. Both the caregiver and the care recipient must sign the Signature Page (Appendix E). The care recipient must at a minimum sign the following:

- Privacy Practices and Individual Rights and Responsibilities
- Release of Information for Statistical Reporting
- Title VI
- Authorization for Referral for Services
- Client Agreement

A reassessment is required at least annually; however, staff should be alert for changes in a caregiver's condition or circumstances that may warrant a reassessment at an earlier date. Follow-up calls should be made quarterly to ensure that the needs of the caregiver are being met.

Follow-up calls should be documented in a case note in the record of the caregiver.

Respite and Supplemental services provided through Title III-E must comply with policies and procedures of the service being provided. For example, a caregiver and/or care recipient that receives home-delivered meals through the NFCSP must comply with Nutrition guidelines.

11-1-.10: Reporting Requirements

TCAD is required to submit the State Reporting Tool (SRT) on an annual basis that includes data on the NFCSP. The NFCSP is on the federal fiscal year, October 1 through September 30. The NFCSP section of the State Reporting Tool (SRT) shall be submitted quarterly the 20th day of the month following the end of the quarter. When the due date falls on a weekend or holiday, the report will be due on the following business day. Required reports must be submitted to TCAD according to the instructions, schedule, and form(s) provided. The year-end report should include data for the entire fiscal year.

Each AAAD shall maintain program data and client information for each service provided through the NFCSP.

(1) The following demographic data for each caregiver must be entered into the SAMS database in order to count. An aggregate number may not be entered. Demographic data should include the following:

- (i) Name
- (ii) Address
- (iii) Telephone number
- (iv) Age
- (v) Gender
- (vi) Race/ethnicity
- (viii) Rural status (usually determined by the AAAD based on address information)
- (ix) Name and relationship to the care recipient
- (x) Optional: Cell phone number or Email address, if available

(2) The only service that is excluded from entering demographic data is Group Information. For this service, an aggregate number can be entered.

(3) For Individual Counseling, Support Groups, and Caregiver Training, a unit of service is equal to a session. Each caregiver will receive a unit of service for each session he/she attend.

(4) Home-delivered meals served with Title III-E funds may be counted as a Nutrition Services Incentive Program (NSIP) eligible mean **if** the meal:

(a) meets the requirements of the OAA (Title III-C);

(b) is served by an agency that has a grant or contract with TCAD or AAAD; and

(c) is served to an individual qualified for service under Title III of the OAA:

(i) care recipients, who are age 60 and over;

(ii) caregivers, who are age 60 or older; or

(iii) caregivers, regardless of age, that are the spouse of a care recipient who is age 60 or older.

11-1-.11: Long Distance Caregivers

There are two (2) types of long distance caregivers:

(1) The caregiver lives within the State of Tennessee and the care recipient lives in another State.

(2) The caregiver lives in another State and the care recipient lives within the State of Tennessee.

Caregiver services may be provided to long distance caregivers whose care recipient resides within the State of Tennessee, if funds are available. However, the decision to provide Respite and Supplemental services to long distance caregivers will be done on a case-by-case basis and must be pre-approved by TCAD. Title III-B or Title III-C in-home services or state funding home and community based services should be considered first if the care recipient is eligible to receive services under those programs. If the caregiver resides in Tennessee and the care recipient resides within another state, the Tennessee AAAD should make a referral to the AAA in the State where the care recipient lives.

11-1-.12: Volunteers

Each AAAD shall make use of trained volunteers to expand the provision of the five (5) service components. The AAAD should work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants (such as organizations carrying out Federal service programs administered by the Corporation for

National and Community Service) in community service settings. Such programs include Senior Corps and AmeriCorps (VISTA).

11-1-.13: Background Checks

This program must be in compliance with the Background Check Chapter of the TCAD *Program and Policy Manual.*

11-1-.14: Cost Sharing and Participant Contribution Requirements

Cost sharing and participant contribution requirements shall be at the discretion of the AAAD. However, if the AAAD chooses to implement cost share, then cost share should be calculated on the care recipient's income with the payment being the responsibility of the caregiver. (See the HCBS chapter for cost share standards.)

Appendix A

Caregiver Assessment

Caregiver Form 2010a

I. Profile

I.A. Caregiver Identification

1. **What is the date of the assessment?**

   ____/____/_____

2. **Specify the type of assessment, or the reason for the assessment.**

   - ☐ Initial assessment
   - ☐ Reassessment

3. **What is the name of the person conducting this assessment?**

4. **What is the name of the agency the assessor works for?**

5. **What is the client's first name?**

6. **What is the client's last name?**

7. **What is the client's middle initial?**

8. **Enter the client's residential street address or Post Office box.**

9. **Enter the client's residential city or town.**

10. **Enter the client's state of residence.**

11. **Enter the client's residential zip code.**

12. **Enter the client's mailing street address or Post Office box.**

13. **Enter the client's mailing city or town.**

14. **Enter the client's mailing state.**

15. **Enter the client's mailing ZIP code.**

16. **What is the client's social security number (SSN)?**

    _____-_____-_____

17. **Enter the primary local client identifier for the client.**

18. **Enter the client's telephone number.**

19. **Alternate telephone number for client**

20. **What is the client's gender?**

    - ☐ Female
    - ☐ Male

21. **What is the client's date of birth?**

    ____/____/_____

22. **Enter the age of the client in years.**

    ☐

23. **Select the client's current marital status.**

    - ☐ Divorced
    - ☐ Legally Separated
    - ☐ Married
    - ☐ Single
    - ☐ Widowed

24. **What is the client's primary caregiver's ethnicity?**

    - ☐ Hispanic or Latino
    - ☐ Not Hispanic or Latino
    - ☐ Unknown

25. What is the client's race?

- ☐ American Indian/Native Alaskan
- ☐ Asian
- ☐ Black/African American
- ☐ Missing
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Non-Minority (White, non-Hispanic)
- ☐ Other
- ☐ White-Hispanic

26. Is the client currently employed?

- ☐ Full time
- ☐ Part time
- ☐ No

I.B. Caregiver Profile

1. What is the care recipient's last name?

_____

2. What is the care recipient's first name?

_____

3. Does the client live with the care recipient?

- ☐ No
- ☐ Sometimes
- ☐ Yes

4. What is the relationship of the client to the care recipient?

- ☐ Daughter/Daughter-in-law
- ☐ Grandparent (60+)
- ☐ Husband
- ☐ Non-relative
- ☐ Other elderly non-relative (55+)
- ☐ Other elderly relative
- ☐ Other relative
- ☐ Relationship Missing
- ☐ Son/Son-in law
- ☐ Wife

5. What is the care recipient's status.

- ☐ Alzheimer's disease or related disorder
- ☐ Client elderly (60+)
- ☐ Disabled (18 to 59)
- ☐ Minor (18 and under)

6. How long has client provided most of the care?

- ☐ Less than 6 months
- ☐ 6 to 12 months
- ☐ 1 to 2 years
- ☐ 2 to 5 years
- ☐ 5+ years

7. Does the client have any other caregiving responsibilities? (Children, other adults, etc.)

_____

_____

_____

_____

8. Describe any significant changes or events that have taken place in the client's life during the last six months.

_____

_____

_____

_____

9. Are there other persons who can assist the client with the care recipient if the client is not available?

- ☐ No
- ☐ Yes

10. What contacts/services/supportive interventions have been provided for the client?

_____

_____

_____

_____

11. Do others assist the client with the care recipient?

- ☐ No
- ☐ Yes

II. Caregiving Tasks

II.A. Type of Service

1. Does the primary client provide the care recipient with personal care?

- [ ] Yes
- [ ] No

2. Does the client help the care recipient with housekeeping?

- [ ] Yes
- [ ] No

3. Does the client help the care recipient manage his/her money?

- [ ] Yes
- [ ] No

4. Does the client help the care recipient with shopping and/or errands?

- [ ] Yes
- [ ] No

5. Does the client help the care recipient with taking medication?

- [ ] Yes
- [ ] No

6. Does the client provide the care recipient with transportation?

- [ ] Yes
- [ ] No

7. Does the client provide the care recipient with other assistance?

- [ ] Yes
- [ ] No

8. If services were not in place, would there be anything that would make it difficult for the client to provide care?

- [ ] Yes
- [ ] No

9. How often does the care recipient receive assistance from the client?

- [ ] Monthly
- [ ] Weekly
- [ ] One to two times per week
- [ ] Three or more times per week
- [ ] Once daily
- [ ] Several times during day
- [ ] Several times during day and night

III. Impact of Caregiving

III.A. Caregiver Challenges

1. How does the client rate his/her health?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

2. Does the client feel that s/he has lost control of his/her life since the care recipient became ill?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

3. Does the client feel that his/her health has suffered because of involvement with the care recipient?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

4. Does the client feel that the care recipient affects his/her relationship with family members/friends in a negative way?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

5. Does the client feel that his/her social life has suffered because s/he is caring for the care recipient?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

6. Does the client feel that s/he doesn't have enough privacy because of caring for the care recipient?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

7. Does the client feel that s/he does not have enough time for him/herself because of the time spent caring for the care recipient?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

8. Does the client feel stressed between caring for the care recipient and trying to meet other responsibilities?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

9. Does the client feel angry when s/he is around the care recipient?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

10. Does the client feel that s/he does not have enough money to take care of the care recipient and pay for the rest of his/her expenses?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

11. Overall, does the client feel burdened caring for the care recipient?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Frequently

12. Indicate the behaviors the care recipient has demonstrated at least one a week.

- ☐ Delusional
- ☐ Disruptive behavior
- ☐ Getting lost/wandering
- ☐ Impaired decision-making
- ☐ Memory deficit
- ☐ Physical aggression
- ☐ Verbal disruption
- ☐ Not applicable

Title :

Date

Title :

Date

Appendix B

Action Plan

ACTION PLAN

☐ Initial	☐ Review	Individual:	Individual Id:

Individual Phone #:	County:	If NFCSP, Care Recipient Name:

Physcian's Name:	Physician's #:
Emergency Contact:	Phone #:

INDIVIDUAL'S NEEDS

(This section should detail specific in-home support services needed in order to maintain the Individual's independence.)

Needs of the Individual	Specific Actions for Addressing Needs	Goals

SERVICE AUTHORIZED

Services Authorized	Funding Source	Provider Name	Frequency and/or Duration	Total Units	Unit Cost	6 Month or Annual Cost	Auth Date	Start Date	End/ Revision Date

Total Amount of Authorized Services		Initials of Individual for 1st Page:

Individual Name:	Individual Id:

INFORMAL SUPPORT AND OTHER COMMUNITY SUPPORTS TO INDIVIDUAL

(This section should detail services that are being provided by informal supports and other community supports. Support service may include services that already exist and/or services they are willing to provide in order to meet the needs of the individual.)

Type of Support to be Provided	Name of Person or Community Resource to Provide Support	Frequency

Next Review: __ 6 Months __ 12 Months __ Other: _____ Date:	**Effective Date:**

Cost Share Required?	☐ Yes	☐ No	

I, the Individual or Authorized Representative, have been involved in developing this action plan. I understand that it may be revised as my preferences and needs change and that I will be notified in advance of changes to the service plan. I have been given the option to choose my providers for services.

Signature of Individual or Authorized Representative:	Date:
Signature of Options Counselor:	Date:
Signature of AAAD Authorized Designee:	Date:

Appendix C

Cost Share Forms

COST SHARE WORKSHEET

OPTIONS, OAA

Name _____ Date: _____

DOB _____ Id#: _____

1

Household Size	1	2
Declared Monthly Income	$0.00	$0.00
200% of FBR (*Update yearly*)	$1,470.00	$ 2,206.00
Income Subject to Cost Share	**-$1,470.00**	**-$2,206.00**

2 Action Plan Estimation (HDM is subject to donation only)

	Units/Month or Year	Unit Cost	Total
Homemaker	0	$ -	$ -
Personal Care	0	$ -	$ -

Monthly or Yearly Cost Estimate for Service $ -

3 **Cost Share Rate** (Income subject to Cost Share divided by the amount given for the appropriate number in the household)

Cost Share Rate:	-50.00%
	-50.00%

1	$ 2,940.00	(Update yearly with FBR x 4)
2	$ 4,412.00	(Update yearly with FBR x 4)

4 **Cost Share**

$0.00	Household 1
$0.00	Household 2

Options Counselor _____ Date _____

Note: The amount of cost share cannot exceed 45% of their declared income

Note: If cost share is less then $25/month, the Individual will not be required to pay

If assessed a cost share, 1 copy for Fiscal and original for file

FINANCIAL RESOURCES-INCOME

Name:	**Id:**

Income

INCOME	Individual	Spouse (if applicable)
Social Security		
SSI		
Retirement/Pension		
Interest from Savings, CDs, etc		
VA Benefits		
Wages/Salaries/Earnings		
Other (specify)		
TOTAL	0	

Savings/Assets

Type of Asset	Amount	Comments
Checking		
Savings		
CDs		
Other		

Monthly Living Cost

SOURCE	AMOUNT PER MONTH	COMMENTS
Rent/Mortgage		
Heat		
Electric		
Water/Garbage		
Telephone		
Cable		
Property Tax		
Home Insurance/Rental Insurance		
Medical Insurance		
Medications		
Transportation		
Other (specify)		
Other (specify)		
Other (specify)		
Other (specify)		
Other (specify)		
Other (specify)		
Other (specify)		
Other (specify)		
Other (specify)		
Other (specify)		
TOTAL	0	

Available Income	0	

Fee Waived: _____ Yes ____ No

Options Counselor		Date:	

Comments:

Appendix D

Missed Visit Report

MISSED VISIT REPORT

Individual's Name: _____ **Id#:** _____

If NFCSP, Care Recipient Name: _____ **Id#:** _____

Provider Agency: _____ **County:** _____

Program *(check one)*: ☐ **OPTIONS** ☐ **NFCSP (Caregiver, Title III-E)** ☐ **OAA (Title III)**

Dates of Missed Visit: _____

_____

Type of Visit:

☐ Personal Care ☐ Home Delivered Meals ☐ In-Home Respite

☐ Homemaker ☐ Other: _____

Reason for Missed Visit:

☐ Individual/Care Recipient had unscheduled appointment

☐ Individual/Care Recipient hospitalized

☐ Individual/Care Recipient refused services

☐ Individual/Care Recipient refused alternate staff member services

☐ Individual/Care Recipient unavailable: ☐ Hospital ☐ Nursing Home ☐ Other:

_____

☐ Knocked – No Response: Contact Person Notified/Response: _____

☐ Called – No Answer: Contact Person Notified/Response: _____

☐ Scheduling error

☐ Hazardous weather

☐ Holiday scheduling – ☐ Provider canceled ☐ Individual/Care Recipient canceled

☐ Provider unable to provide service because: _____

_____

Additional Provider Comments: _____

_____

Signature of Agency Representative: _____ **Date:** _____

AAAD Use Only: ☐ Provider Liable ☐ Consumer Liable ☐ No Fault

FAX/SCAN WITHIN 5 BUSINESS DAYS OF MISSED VISIT TO AAAD

Appendix E

Signature Page

SIGNATURE PAGE

Individual's Name: _____ **Individual's ID:** _____

☐ **AGE DECLARATION** – I am unable to provide proof of age and I declare that I am 60 years of age or older and that my date of birth, _____ (Month/Day/Year), is correct to the best of my knowledge.

☐ **ASSESSMENT** – I certify that the information provided to the Options Counselor regarding my medical, social and financial circumstances is accurate and complete. I understand that if it is determined at a later date that the information collected is incorrect, my eligibility for services may be affected.

☐ **CHOICE OF PROVIDERS** – I have been offered a choice of service providers from a list of available companies in my county for each service I am authorized to receive. I understand that it is my choice as to whom I want to provide the in-home services.

☐ **PRIVACY PRACTICES AND INDIVIDUAL RIGHTS AND RESPONSIBILITIES** – By signing this form I acknowledge that I have received a copy of the Notice of Privacy Practices and a copy of the Individual Rights and Responsibilities. I also acknowledge that I understand the information provided in the Notice of Privacy Practices and the Rights and Responsibilities.

☐ **RELEASE OF INFORMATION FOR STATISTICAL REPORTING –** I understand that the information collected will not be identified with me personally. It may be used in statistical reports. I give my permission to use the information for statistical reporting.

☐ **REQUEST FOR INTERAGENCY INFORMATION SHARING** – I receive services for more than one program funded through the Tennessee Commission on Aging and Disability and the Area Agency on Aging and Disability. I request the information from my assessment be shared with agencies that would otherwise have to interview me again to collect the same data.

☐ **SERVICES POLICY** – I understand that initiating/continuing services is based upon the availability of funding from State/Federal sources. Additionally, change(s) in Individual circumstances may determine eligibility for an increase or decrease in services.

☐ **TITLE VI** – I understand that I have the right not to be discriminated against on the ground of race, color, or national origin. I understand the procedures for filing a complaint if I feel that I have been discriminated against.

☐ **VOLUNTARY CONTRIBUTIONS** – I understand how to make a voluntary contribution to help pay for the cost of my services paid for by the AAAD. I understand that my contribution can be made anonymously and/or confidentially if that is my preference.

_____ _____

Initials of Individual/Authorized Representative Date

Individual's Name: _____ **Individual's ID:** _____

☐ **COST SHARING** – I understand there is a possibility that I will have cost share and that I will be receiving a letter informing me about my cost sharing responsibilities if my income exceeds 200% of the Federal Benefit Rate. I understand that prior to my services starting, I will be informed of my costs, if any.

☐ **RECEIPT OF ADVANCED DIRECTIVE INFORMATION** – I have received written information on my right to formulate advanced directives.

☐ **PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)** – I understand that if I have PERS equipment and I am no longer receiving PERS services that the equipment will be removed from the home at the discontinuation of the service.

☐ **NUTRITION COUNSELING** – I understand that due to identified nutritional risk factors, I have been referred for Nutrition Counseling. ☐ Accept or ☐ Deny

☐ **AUTHORIZATION FOR REFERRAL FOR SERVICES** – I give permission for the Area Agency on Aging and Disability to contact, on my behalf, the agencies or persons listed below and/or on my Action Plan and to release only such information to them as may be needed to determine the level and types of services that I may need. I also grant permission to the receiving agencies to report back regarding services that I may or may not receive and/or any additional information that may significantly reflect on my need for services. This authorization may be revoked at any time by my written statement, and is automatically revoked at my transfer from the agency or at notification of death to include a period of six (6) months.

AGENCY	PURPOSE
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

☐ **CLIENT AGREEMENT** – By my signature, I affirm that I have read, or have had explained to me, the above statements. The telephone number I need for questions or complaints has been left with me, and I do give the authorization for release of information as listed above. Unless otherwise stated, this expires in one year.

_____ _____
Signature of Individual or Authorized Representative Date

_____ _____
Signature of Options Counselor Date

Appendix F

Provider Authorization/Notification of Change

PROVIDER AUTHORIZATION/NOTIFICATION OF CHANGE

☐ **Service Start** ☐ **Service Change** ☐ **Change of Information** ☐ **Service End**

☐ **Hold as of:** _____ ☐ **Resume Services as of:** _____

I. Individual's Information

Name:	DOB:	Id#:	County:
Street Address:		City/Zip Code:	
Phone #:	Emergency Contact:	EC Phone #:	
If Title III-E (NFCSP), Name of Care Recipient:		Care Recipient Id#:	

II. Service Authorization

Service	Date Service Authorized	Provider Name	Funding Source	Units/ Frequency	Unit Cost	End Date
Homemaker						
Personal Care						
Home Delivered Meal						
Chore						
In-Home Respite						
Adult Day Care						
Other:						

Special Frequency Instructions:

Comments/Considerations:

Options Counselor: _____ Phone: _____

Date Faxed: _____ If Change of Services, Date Individual Notified: _____

III. Service Provider

☐ Accepted ☐ Declined Service Start Date: _____ Date Ended: _____

Authorized Provider Signature: _____ Date: _____

FAX/SCAN REPLY WITH START DATE WITHIN 5 WORKING DAYS TO AAAD

Appendix G

Provider Checklist

PROVIDER CHECKLIST

Date: _____ **County:** _____

Individual's Name: _____ **Id#:** _____

If NFCSP, Care Recipient: _____ **Id#:** _____

☐ PERSONAL CARE

Type of Bath:
- ☐ Tub Bath
- ☐ Shower
- ☐ Complete bed bath
- ☐ Complete sponge bath
- ☐ Partial sponge bath

Foot Care:
- ☐ Foot soak
- ☐ Lotion Feet
- ☐ Other _____

Hair Care:
- ☐ Shampoo in shower
- ☐ Shampoo in sink
- ☐ Shampoo in bed
- ☐ Brush hair
- ☐ Shave
- ☐ Other_____

Mouth Care:
- ☐ Brush teeth
- ☐ Clean dentures
- ☐ Swab mouth

Dressing:
- ☐ Dressing Assistance

Skin Care:
- ☐ Lotion massage
- ☐ Other_____

Nail Care:
- ☐ Clean nails
- ☐ Other_____

Ambulation:
- ☐ Assist to ambulate
- ☐ With assistive device
- ☐ Do not ambulate

Other Duties:
- ☐ Assist with eating
- ☐ Assist with toileting

☐ HOMEMAKER

- ☐ Straighten/Pick up
- ☐ Vacuuming
- ☐ Mop
- ☐ Laundry/Laundromat
- ☐ Dusting
- ☐ Empty trash
- ☐ Prescription pickup
- ☐ Shopping
- ☐ Grocery shopping

Bedroom:
- ☐ Change bed linen
- ☐ Straighten bed linen
- ☐ Other_____

Bathroom:
- ☐ Clean tub/shower
- ☐ Clean bath basin
- ☐ Clean commode
- ☐ Other_____

Kitchen:
- ☐ Clean stove
- ☐ Clean countertop
- ☐ Clean refrigerator
- ☐ Clean dishes
- ☐ Meal preparation
- ☐ Other_____

☐ Special Instructions:

☐ Safety needs identified:

_____ _____

Signature of Individual or Authorized Representative **Date**

Appendix H

Reimbursement Rate of Services

Reimbursement Rate

OPTIONS for Community Living (State-Funded)
Older Americans Act – Title III (Federally Funded)

Service	Reimbursement Rate
Personal Care – OAA Title III	*The lesser of* $20.32 per hr. or usual and customary charges*
Personal Care – State Funds	*The lesser of* $20.32 per hr. or usual and customary charges*
Homemaker Services – OAA Title III	*The lesser of* $20.32 per hr. or usual and customary charges*
Homemaker Services – State Funds	*The lesser of* $20.32 per hr. or usual and customary charges*
In-home Respite – OAA Title III	*The lesser of* $16.12 per hr. or usual and customary charges*
Hot Home-Delivered Meals – OAA Title III	*The lesser of* $6.93 per meal or usual and customary charges*
Hot Home-Delivered Meals – State Funds	*The lesser of* $6.93 per meal or usual and customary charges*
Frozen Home-Delivered Meals – OAA Title III	*The lesser of* $5.94 per meal or usual and customary charges*
Frozen Home-Delivered Meals – State Funds	*The lesser of* $5.94 per meal or usual and customary charges*

**For providers who have not established usual and customary charges, the charge should be reasonably related to the provider's cost for providing the service. The same requirements are to be applied in the above noted programs. Thus, only the lesser of the maximum rate as specified above or the usual and customary charges for each service should be billed.*

These are the maximum rates which may **not** be exceeded; a lesser amount should be billed and reimbursed, if the provider's usual and customary charge to persons not participating in these programs is lower. Reimbursement rates for OAA and State-Funded services shall not exceed the TennCare reimbursement rates.

Appendix I

Social Assistance Management System Independent Living Assessment (SAMS ILA) 2016

SAMS ILA 2016

A	Intake/Assessment			Req?
	Intake/Assessment	1144 1	What is the date of the assessment? ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year)	Yes
		1145 2	Specify the type of assessment, or the reason for the assessment. ☐ 1 Initial assessment ☐ 2 Reassessment	Yes
		1001 3	What is the name of the person conducting this assessment?	Yes
		2999 4	Describe formal/informal supports already in place.	No
		5695 5	Comment on type of assistance requested.	Yes

B	Individual Identification			Req?
	Individual Identification	1128 1	What is the client's first name?	Yes
		1493 2	Enter the client's 'also known as' first name.	No
		1129 3	What is the client's middle initial?	No
		1127 4	What is the client's last name?	Yes
		1134 5	What is the client's date of birth? ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year)	Yes
		4297 6	What document was used to verify the client's age? ☐ 1 Birth certificate	Yes

B	Individual Identification			Req?
		☐ 2	State issued identification	
		☐ 3	Military/veteran's identification card	
		☐ 4	Self declaration	
		☐ 5	Other (Answer next question if this is chosen)	
	4298	7	What other document was used to verify the client's age?	No
	1131	8	What is the client's Pension/Social Security Number? (Optional) ___-___-___	No
	1495	9	Enter the client's telephone number.	Yes
	6627	10	Alternate telephone number for client	No
	5362	11	What is the client's e-mail address?	No
	1501	12	Enter the client's residential street address or Post Office box.	Yes
	1502	13	Enter the client's residential city or town.	Yes
	1409	14	Enter the client's residential zip code.	Yes
	1724	15	What county does the client reside in?	Yes
	1505	16	Describe how to get to the client's home.	No
	1497	17	If different from residential address, enter the client's mailing street address or Post Office box.	No
	1498	18	If different from residential address, enter the client's mailing city or town.	No
	1499	19	If different from residential address, enter the client's mailing state.	No

B	Individual Identification			Req?
		1500 20	If different from residential address, enter the client's mailing ZIP code.	No
		1012 21	Select the client's current living arrangement.	Yes
		Score: 3	☐ 1 Lives Alone - 3 ☐ 2 Lives with spouse only ☐ 3 Lives with spouse and others ☐ 4 Lives with others.	

C	Demographics			Req?
	Demographics	4005 1	What is the client's ethnicity?	Yes
			☐ 1 Hispanic or Latino ☐ 2 Not Hispanic or Latino ☐ 3 Unknown	
		4006 2	What is the client's race?	Yes
			☐ 1 American Indian/Native Alaskan ☐ 2 Asian ☐ 3 Black/African American ☐ 4 Native Hawaiian/Other Pacific Islander ☐ 5 White, Non-Hispanic ☐ 6 White, Hispanic ☐ 7 Other	
		1133 3	What is the client's gender?	Yes
			☐ 1 Male ☐ 2 Female ☐ 3 Other	
		1010 4	Select the client's current marital status.	Yes
			☐ 1 Single ☐ 2 Married ☐ 3 Divorced ☐ 4 Widowed ☐ 5 Separated ☐ 6 Other	

D	Caregiver Identification			Req?
	Caregiver Identification	1066 1	Does the client have an identified primary (informal) helper/caregiver who provides care on a regular basis?	Yes
			☐ 1 Yes ☐ 2 No, If no, skip to next section.	
		4732 2	What is the caregiver's first name?	No

D	Caregiver Identification			Req?
	4731	3	What is the caregiver's last name?	No
	2531	4	Caregiver's birth date? ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year)	No
	4734	5	What is the caregiver's telephone number?	No
	5363	6	What is the caregiver's e-mail address?	No
	2545	7	What is the address of the client's caregiver?	No
	2548	8	What is the client's caregiver's Zip Code?	No
	5360	9	What is the caregiver's relationship to the elderly care recipient? ☐ 1 Child ☐ 2 Spouse/Partner/Significant other ☐ 3 Other relative ☐ 4 Other non-relative	No
	1429	10	How often does the client receive assistance from the primary caregiver? ☐ 1 Daily ☐ 2 Several times a week ☐ 3 Weekly ☐ 4 Less than weekly	No

E	Emergency Contacts			Req?
	Emergency Contacts	2400	1	Name of Friend or Relative (outside client's home) to contact in case of an Emergency.	Yes
		2401	2	Relationship of Friend or Relative (outside client's home) to contact in case of an Emergency.	Yes
		2402	3	Primary Telephone Number of Friend or Relative (outside client's home) to contact in case of an Emergency.	Yes

E	Emergency Contacts			Req?
		2403 4	Alternate Telephone Number of Friend or Relative (outside client's home) to contact in case of an Emergency.	No
		1040 5	What is the name of a second relative or friend of the client?	No
		1503 6	What is the home phone number of the second relative or friend of the client?	No
		1504 7	What is the alternate phone number of the second relative or friend of the client?	No
		1514 8	Does the client have a power of attorney? ☐ 1 Yes, Health ☐ 2 Yes, Finances ☐ 3 Yes, Both ☐ 4 No (If no, skip to question #11) ☐ 5 Don't Know (If don't know, skip to question # 11)	No
		1515 9	What is the name of the client's power of attorney?	No
		1517 10	Enter the phone number of the client's power of attorney.	No
		2228 11	Does the client have a living will? ☐ 1 Yes ☐ 2 No	No

F	Social Screening			Req?
	Social Screening	1559 1	Is there a friend or relative that could take care of the client for a few days? ☐ 1 Yes ☐ 2 No	Yes
		2215 2	Is the client satisfied with his/her current level of socialization? ☐ 1 Yes ☐ 2 No	Yes
		3969 3	Does the client have limitations that prevent them from participating in social activities? ☐ 1 Yes ☐ 2 No	Yes

G	Health Screening			Req?
	Health Screening	1561 1	How does the client rate his/her health?	Yes

G	Health Screening			Req?
			☐ 1 Excellent ☐ 2 Good ☐ 3 Fair ☐ 4 Poor	
		4292 2	In the past year, how many times has the client stayed overnight in a hospital? ☐ 1 Not at all ☐ 2 Once ☐ 3 2 or 3 times ☐ 4 More than 3 times	Yes
		1566 3	Has the client fallen in the past three months? ☐ 1 Yes ☐ 2 No	Yes
		2714 4	Is the client homebound? ☐ 1 Yes ☐ 2 No	Yes
		1124 5	Indicate which of the following conditions/diagnoses the client currently has. ☐ 1 Diabetes ☐ 2 Breathing disorders ☐ 3 Heart disease/problems ☐ 4 Hypertension ☐ 5 Stroke ☐ 6 Cancer ☐ 7 Intellectual/developmental disability ☐ 8 Alzheimer disease/other dementia ☐ 9 Anxiety disorder ☐ 10 Depression ☐ 11 Manic depression (bipolar disease) ☐ 12 Schizophrenia	Yes
		1126 6	Enter any comments regarding the client's medical conditions/diagnoses. _____ _____ _____	No

H	Mental Health Observations			Req?
	Mental Health Observations	7406 1	Can the client express basic needs and wants? ☐ 1 Yes ☐ 2 No	No

H	Mental Health Observations			Req?
	1936 2	How many days per week does the client have problems making him/herself understood?		No
		☐ 1	Never	
		☐ 2	Less than daily	
		☐ 3	Daily	
		☐ 4	Multiple times per day	
		☐ 5	Unknown	
	7391 3	Can the client understand and follow simple instructions?		No
		☐ 1	Yes	
		☐ 2	No	
	1938 4	How many days per week does the client have problems understanding others?		No
		☐ 1	Never	
		☐ 2	Less than daily	
		☐ 3	Daily	
		☐ 4	Multiple times per day	
		☐ 5	Unknown	
	8386 5	Is the client oriented to person, place, time?		No
		☐ 1	Yes	
		☐ 2	No	
	4089 7	Indicate worker's judgment of client's overall mental clarity/cognitive functions.		Yes
		☐ 1	Good	
		☐ 2	Fair	
		☐ 3	Poor	

I	ADL/IADL and Other Limitations			Req?
	ADL	1081 1	During the past 7 days, and considering all episodes, was the client able to BATHE without help?	Yes
			☐ 1 Yes (Skip next question)	
		Score: 1	☐ 2 No, required assistive technology (Skip next question) - 1	
		Score: 2	☐ 3 No, required supervision (Skip next question) - 2	
		Score: 3	☐ 4 No, required limited assistance - 3	
		Score: 4	☐ 5 No, required extensive assistance - 4	
		Score: 5	☐ 6 No, required total assistance - 5	
		9189 2	How many days per week does the client require assistance BATHING?	No
			_____	
			_____	
		1077 3	During the past 7 days, and considering all episodes, was the client able to Dressing without help?	Yes
			☐ 1 Yes (Skip next question)	
		Score: 1	☐ 2 No, required assistive technology (Skip next question) - 1	

I	ADL/IADL and Other Limitations			Req?
	Score: 2	☐ 3	No, required supervision (Skip next question) - 2	
	Score: 3	☐ 4	No, required limited assistance - 3	
	Score: 4	☐ 5	No, required extensive assistance - 4	
	Score: 5	☐ 6	No, required total assistance - 5	
	9190 4	How many days per week does the client require assistance DRESSING?		No
	1074 5	During the past 7 days, and considering all episodes, was the client able to TRANSFER without help?		Yes
		☐ 1	Yes (Skip next question)	
	Score: 1	☐ 2	No, required assistive technology (Skip next question) - 1	
	Score: 2	☐ 3	No, required supervision (Skip next question) - 2	
	Score: 3	☐ 4	No, required limited assistance - 3	
	Score: 4	☐ 5	No, required extensive assistance - 4	
	Score: 5	☐ 6	No, required total assistance - 5	
	4953 6	How many days per week does the client require assistance TRANSFERRING		No
	1076 7	During the past 7 days, and considering all episodes, was the client able to GET AROUND THE HOME without help?		Yes
		☐ 1	Yes (Skip next question)	
	Score: 1	☐ 2	No, required assistive technology (Skip next question) - 1	
	Score: 2	☐ 3	No, required supervision (Skip next question) - 2	
	Score: 3	☐ 4	No, required limited assistance - 3	
	Score: 4	☐ 5	No, required extensive assistance - 4	
	Score: 5	☐ 6	No, required total assistance - 5	
	9197 8	How many days per week does the client require assistance GETTING AROUND THE HOME?		No
	1078 9	During the past 7 days, and considering all episodes, was the client able to EAT without help?		Yes
		☐ 1	Yes (Skip next question)	
	Score: 1	☐ 2	No, required assistive technology (Skip next question) - 1	
	Score: 2	☐ 3	No, required supervision (Skip next question) - 2	
	Score: 3	☐ 4	No, required limited assistance - 3	
	Score: 4	☐ 5	No, required extensive assistance - 4	
	Score: 5	☐ 6	No, required total assistance - 5	

I	ADL/IADL and Other Limitations			Req?
		9191 10	How many days per week does the client require assistance EATING?	No
		1079 11	During the past 7 days, and considering all episodes, was the client able to USE THE TOILET without help?	Yes
			☐ 1 Yes (Skip next question)	
		Score: 1	☐ 2 No, required assistive technology (Skip next question) - 1	
		Score: 2	☐ 3 No, required supervision (Skip next question) - 2	
		Score: 3	☐ 4 No, required limited assistance - 3	
		Score: 4	☐ 5 No, required extensive assistance - 4	
		Score: 5	☐ 6 No, required total assistance - 5	
		9199 12	How many days per week does the client require assistance USING THE TOILET?	No
		2118 13	How many ADL impairments does the client have (Count)?	Yes
	IADL	1084 1	During the past 7 days, and considering all episodes, was the client able to MANAGE MEDICATIONS without help?	Yes
			☐ 1 Yes (Skip next question)	
		Score: 1	☐ 2 No, required assistive technology (Skip next question) - 1	
		Score: 2	☐ 3 No, required supervision (Skip next question) - 2	
		Score: 3	☐ 4 No, required limited assistance - 3	
		Score: 4	☐ 5 No, required extensive assistance - 4	
		Score: 5	☐ 6 No, required total assistance - 5	
		9196 2	How many days per week does the client receive physical assistance MANAGING MEDICATIONS?	No
		1901 3	Is the client able to MANAGE MONEY without help?	Yes
			☐ 1 Yes	
		Score: 1	☐ 2 No - 1	
		1086 4	Is the client able to SHOP without help?	Yes
			☐ 1 Yes	
		Score: 1	☐ 2 No - 1	
		1082 5	Is the client able to PREPARE MEALS without help?	Yes
			☐ 1 Yes	
		Score: 1	☐ 2 No - 1	
		1902 6	Is the client able to do HEAVY HOUSEWORK without help?	Yes

I	ADL/IADL and Other Limitations			Req?
			☐ 1 Yes	
		Score: 1	☐ 2 No - 1	
		1903 7	Is the client able to do LIGHT HOUSEKEEPING without help?	Yes
			☐ 1 Yes	
		Score: 1	☐ 2 No - 1	
		1087 8	Is the client able to USE TRANSPORTATION without help?	Yes
			☐ 1 Yes	
		Score: 1	☐ 2 No - 1	
		3820 9	Is the client able to USE THE TELEPHONE without help?	Yes
			☐ 1 Yes	
		Score: 1	☐ 2 No - 1	
		2119 10	How many IADL impairments does the client have (Count or Total)?	Yes
	Adaptive Equipment	5380 1	Does the client have any of the following devices or equipment?	No
			☐ 1 Artificial limb	
			☐ 2 Bath stool	
			☐ 3 Bedside commode	
			☐ 4 Cane	
			☐ 5 Dentures	
			☐ 6 Extended shower head	
			☐ 7 Eyeglasses	
			☐ 8 Grab bars	
			☐ 9 Hand Held Shower	
			☐ 10 Hearing aid	
			☐ 11 Hospital bed	
			☐ 12 Lift chair	
			☐ 13 Nebulizer	
			☐ 14 Oxygen	
			☐ 15 Raised toilet seat	
			☐ 16 Ramp	
			☐ 17 Walker	
			☐ 18 Wheelchair	
			☐ 19 Other	
		6772 2	Please specify the other assistive devices the client uses.	No
		4384 3	Comment on the client's functional ability.	No

I	ADL/IADL and Other Limitations			Req?
		5785 4	If the client did not receive agency funded services, would the client have enough help to remain independent? ☐ 1 Yes, without difficulty ☐ 2 Yes, with difficulty ☐ 3 No/not sure	No

J	Nutrition Screening			Req?
	Nutrition Screening	2383 1 Score: 2	Has the client made any changes in lifelong eating habits because of health problems? ☐ 1 Yes - 2 ☐ 2 No	Yes
		1108 2 Score: 3	Does the client eat fewer than 2 meals per day? ☐ 1 Yes - 3 ☐ 2 No	Yes
		1110 3 Score: 2	Does the client have 3 or more drinks of beer, liquor or wine almost every day? ☐ 1 Yes - 2 ☐ 2 No	Yes
		2384 4 Score: 1	Does the client eat fewer than five (5) servings (1/2 cup each) of fruits or vegetables every day? ☐ 1 Yes - 1 ☐ 2 No	Yes
		2385 5 Score: 1	Does the client eat fewer than two servings of dairy products (such as milk, yogurt, or cheese) every day? ☐ 1 Yes - 1 ☐ 2 No	Yes
		1818 6 Score: 2	Does the client have trouble eating well due to problems with chewing/swallowing? ☐ 1 Yes - 2 ☐ 2 No	Yes
		1112 7 Score: 4	Does the client sometimes not have enough money to buy food? ☐ 1 Yes - 4 ☐ 2 No	Yes
		1113 8 Score: 1	Does the client eat alone most of the time? ☐ 1 Yes - 1 ☐ 2 No	Yes
		1114 9 Score: 1	Does the client take 3 or more different prescribed or over-the-counter drugs per day? ☐ 1 Yes - 1	Yes

J	Nutrition Screening			Req?
			☐ 2 No	
		1115 10	Without wanting to, has the client lost or gained 10 pounds in the past 6 months?	Yes
		Score: 2	☐ 1 Yes - 2	
			☐ 2 No	
		1116 11	Is the client not always physically able to shop, cook and/or feed themselves (or to get someone to do it for them)?	Yes
		Score: 2	☐ 1 Yes - 2	
			☐ 2 No	
		2563	Total score of Nutritional Risk Questions.	No
		2116 12	Is the client at a high nutritional risk level?	Yes
			☐ 1 Yes	
			☐ 2 No	

K	Current Health Status			Req?
	Current Health Status	1804 1	Describe the client's allergies, if any.	Yes
		1817 2	Describe the client's special diet(s).	No

L	Home Hazards			Req?
	Home Hazards	4052 1	Is there evidence of pets/animals that are a danger to those who come to the client's home?	No
			☐ 1 Yes	
			☐ 2 No	
		3526 2	Rate evidence of Combative, Abusive or Hostile Behavior.	No
			☐ 1 None	
			☐ 2 Some	
			☐ 3 Severe	

M	Home Environment			Req?
	Environmental Checklist	1941 1	Does the client have problems with dangerous stairs or floors in his/her home?	Yes
			☐ 1 Yes	
			☐ 2 No	

M	Home Environment			Req?
	1942	2	Is it difficult for the client to get to the entrance of his/her home? ☐ 1 Yes ☐ 2 No	Yes
	1943	3	Is it difficult for the client to get to the bathroom or bedroom in his/her home? ☐ 1 Yes ☐ 2 No	Yes
	1944	4	Does the client have problems with the major appliances or toilet in his/her home? ☐ 1 Yes ☐ 2 No	Yes
	1945	5	Does the client have problems with the heating or cooling in his/her home? ☐ 1 Yes ☐ 2 No	Yes
	1946	6	Does the client have problems getting water or hot water in his/her home? ☐ 1 Yes ☐ 2 No	Yes
	1947	7	Does the client have difficulties keeping his/her home free from odor or pests? ☐ 1 Yes ☐ 2 No	Yes
	1948	8	Does the client need a smoke alarm in his/her home? ☐ 1 Yes ☐ 2 No	Yes
	1949	9	Does the client have problems with electrical hazards in his/her home? ☐ 1 Yes ☐ 2 No	Yes
	1950	10	Does the client have problems with poor lighting in his/her home? ☐ 1 Yes ☐ 2 No	Yes
	1951	11	Does the client have problems with an unsafe stove in his/her home? ☐ 1 Yes ☐ 2 No	Yes
	1952	12	Does the client have problems with loose slippery rugs in his/her home? ☐ 1 Yes ☐ 2 No	Yes
	1953	13	Does the client have problems with inadequate locks on the doors and/or windows in his/her home? ☐ 1 Yes ☐ 2 No	Yes

M	Home Environment			Req?
		1954 14	Does the client have problems keeping his/her home clean and free of clutter? ☐ 1 Yes ☐ 2 No	Yes
		1955 15	Does the client have any other environmental problems in his/her home? ☐ 1 Yes ☐ 2 No	Yes
		1956 16	Describe any other environmental problems. _____ _____ _____	Yes
		1957 17	In the case of an emergency, would the client be able to get out of his/her home safely? ☐ 1 Yes ☐ 2 No	Yes
		1958 18	In the case of an emergency, would the client be able to summon help to his/her home? ☐ 1 Yes ☐ 2 No	Yes
		4227 19	Comment on the client's home environment in general. _____ _____ _____	Yes

N	Financial Resources			Req?
	Total Resources	2068 1	What is the total income of the client's (client and spouse only) per month?	Yes
		2115 2	Is the client's income level below the national poverty level? ☐ 2 Yes ☐ 2 No ☐ 3 Don't know	Yes
		3910 2	What is the client's Monthly Income Range? ☐ 1 Below 150% federal poverty level ☐ 2 Below 200% federal poverty level ☐ 3 Below 300% federal benefit rate ☐ 4 Over 300% federal benefit rate	Yes
		5802 3	Does the client have excessive expenses, such as medical bills, that prevent them from meeting their needs? ☐ 1 Yes ☐ 2 No	Yes

N	Financial Resources				Req?
	Other Assistance	1552	1	Does the client want to apply for any of the following services or programs? ☐ 1 Energy assistance (LIHEAP) ☐ 2 Food stamps (SNAP) ☐ 3 Home Repair/Weatherization ☐ 4 QMB/SLMB/LIS/Q1 ☐ 5 SSI ☐ 6 Medicare Counseling ☐ 7 None	No
		2123	2	Is the client a veteran or the spouse/widow of a veteran? ☐ 1 Yes ☐ 2 No	Yes
	Health Insurance	1780	1	Does the client have Medicare A health insurance? ☐ 1 Yes ☐ 2 No (Skip next two questions) ☐ 3 Don't know	Yes
		1002	2	Enter the client's Medicare number. _____	No
		1781	3	What is the effective date of the client's Medicare A policy? ☐☐ – ☐☐ – ☐☐☐☐ Month Day Year	No
		1782	4	Does the client have Medicare B health insurance? ☐ 1 Yes ☐ 2 No (Skip next question) ☐ 3 Don't know	No
		1783	5	What is the effective date of the client's Medicare B policy? ☐☐ – ☐☐ – ☐☐☐☐ Month Day Year	No
		1785	6	Does the client have Medigap health insurance? ☐ 1 Yes ☐ 2 No	No
		5979	7	Does the client have Medicare D health insurance? ☐ 1 Yes ☐ 2 No	No
		1788	8	Does the client have LTC health insurance? ☐ 1 Yes ☐ 2 No	No
		1791	9	Does the client have other health insurance? ☐ 1 Yes	No

N	Financial Resources			Req?
			☐ 2 No	
		2440 10	Comments regarding QMB/SLMB/QI 1/QI 2	No

O	CHOICES Screening			Req?
	CHOICES	5991 1	Does the client own his/her home or any other property? ☐ 1 Yes ☐ 2 No	No
		7140 2	What are the client's resources/assets? ☐ 1 Certificate of Deposits ☐ 2 Checking Account ☐ 3 Savings certificate ☐ 4 IRA or Annuity ☐ 5 Savings Account ☐ 6 Stocks, Bonds ☐ 7 Burial contract ☐ 8 Life insurance policy with cash value ☐ 9 Property other than home	No
		8131 3	Are the Consumer's assets valued at less than $2000? ☐ 1 Yes ☐ 2 No ☐ 3 Don't Know	No
		6332 4	Has the client transferred any property or money in the last five years? ☐ 1 Yes ☐ 2 No	No
		11925 5	While you are more likely to get more services sooner by getting CHOICES, getting CHOICES also means that any property and assets you have are subject to Estate Recovery. Knowing this, would you still like to be screened for CHOICES? ☐ 1 Yes ☐ 2 No	No
		3989 6	What is the date of the consumer's last medical evaluation by a physician? ☐☐ – ☐☐ – ☐☐☐☐ Month Day Year	No
		1025 7	What is the name of the client's primary care physician?	No
		1028 8	What is the work phone number for the client's primary care physician?	No

P	Other Observations				Req?
	Other Observations	4044	1	Client is assigned for in-depth assessment for the following programs?	No
				☐ 1 CHOICES	
				☐ 2 OPTIONS	
				☐ 3 Title IIIE, NFCSP services	
				☐ 4 Title IIIB	
				☐ 5 Title IIIC, Home Delivered Meals	
				☐ 6 None	
		4688	2	Enter intake/referral comments.	No
				_____	
				_____	
				_____	